of Dr. Gibberd and his colleagues in that blood levels in our patients are significantly higher in those prescribed 100 mg. q.i.d. than in those prescribed 100 mg. t.d.s.

Another source of variation in our patients is suggested by the fact that the mean blood levels of patients prescribed phenytoin alone tend to be higher than those of patients prescribed one or more additional drugs. The mean blood levels estimated as the specific benzophenone derivative are 6·9 ± 4·5 μg./ml. (27 observations) in the former, and 5·2 ± 2·6 μg./ml. (112 observations) in the latter. The difference between means is highly significant ($p<·005$).

The additional drugs are most often digoxin, diuretics, anticoagulants, and psychotropic drugs. We have been unable to associate any single one of these with particularly high or low blood levels. When patients are rated on their own estimates of how often they omit a dose of phenytoin, their replies accord with the notion that prescription of additional drugs is associated with more frequent omission of a phenytoin dose than when phenytoin is the only drug prescribed. While at this stage the possibility is not excluded that we are observing the effect of specific drug interactions, it is likely that multiplicity of prescriptions contributes to omission of doses and hence to the variability of blood phenytoin levels.—We are, etc.,

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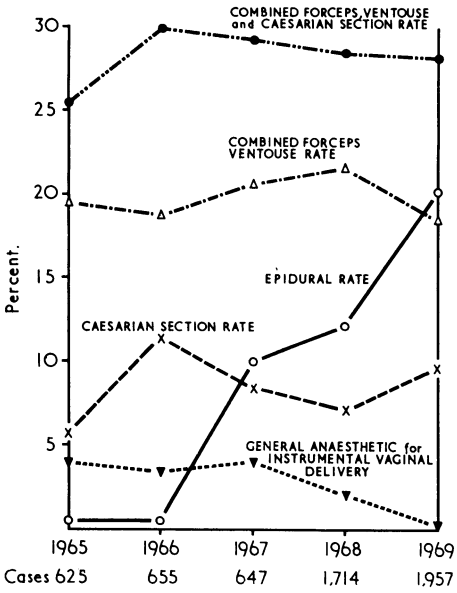
REFERENCE
1 Wallace, J. E., *Journal of Forensic Sciences*, 1966, **11**, 552.

Epidural Analgesia in Labour

SIR,—During the last five years epidural analgesia has been increasingly used in the obstetric departments of this teaching hospital group. Several interesting facts have emerged. Two are of particular interest and are reported here as a graph.



The graph shows all numbers expressed as a percentage of the total number of deliveries per annum. The number of women delivered under epidural analgesia is a steeply rising line.

Though the majority of women given epidural analgesia have an operative delivery, the rising epidural rate has had no effect on the total rate of instrumental delivery. This suggests that common medical indications for epidural analgesia tend to select women who anyway would have required operative help. It is our experience that as the indications widen, and as more "normal" labours are included, so the number of normal deliveries under epidural analgesia increases. We are watching this rising trend with interest. The later figures show that as the epidural rate approaches 30% so the incidence of non-operative deliveries approaches 40%.

The other point of interest is that the number of general anaesthetics for operative vaginal delivery has been reduced from 4% of all deliveries (20% of forceps/ventouse deliveries) to virtually nil. General anaesthesia has recently been confirmed as an important factor in maternal mortality. The last *Confidential Report*[1] showed a rise in deaths both absolutely and relatively.

Apart from any consideration of mortality there are emotional gains. The patients' complete lack of discomfort during a forceps rotation delivery under epidural analgesia is difficult to believe until witnessed.

Our departments are currently delivering more than 400 women annually under epidural analgesia. These are blocks mostly given by junior members of the anaesthetic team. The technique used is that described by J. B. Wyman[2] *et al.* and the drug bupivicaine. We have seen no serious complications.—We are, etc.,

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REFERENCES
1 Arthure, H., *et al.*, *Report on Confidential Enquiries into Maternal Deaths in England and Wales. 1964-1966*. London, H.M.S.O., 1968.
2 Duthie, A. M., Wyman, J. B., and Lewis, G. A., *Anaesthesia*, 1968, **23**, 20.

Recruits for Venereology

SIR,—I would like to comment on Dr. W. Fowler's letter (28 March, p. 816) regarding the difficulty of recruitment to the "unattractive" specialty of venereology. The problem, which is already serious, is likely to get much worse in the next decade owing to the increasing demands made on the relatively small pool of available medical manpower by other more "attractive" disciplines. It should be emphasized here that clinics throughout the country are now seeing more patients than ever before.

To the informed, interested, and enthusiastic doctor no branch of the practice of medicine is unattractive, and to this statement venereology is no exception. Its image, however, as Dr. Fowler points out, *is* unattractive. To my mind there is no simple, single measure which could do so much for the status of the specialty and for the well-being of the majority of our patients as a change of name, such as that suggested in your leading article of 21 February (p. 447).

Venereology is a bad name for a number of reasons. The most important is that a majority of our patients do not have venereal disease. It is therefore unfair to subject them to the stigma which unfortunately in many places is still firmly attached to the V.D. clinic. Many of our colleagues, especially in general practice, are disinclined to refer patients to us with disorders other than true venereal disease for this reason, even though our opinion might be welcomed. This attitude is further reinforced by the appalling premises that the clinics are still compelled to work in. To rename them departments of genito-urinary medicine or some similar title would allow busy practitioners to refer a much wider spectrum of illness without their having to offer wearisome explanations such as: "I am going to ask you to see a doctor who is a specialist in V.D., which I do not think you have, but he is very interested in your problem, etc." Such explanations only confuse the patient and increase his normal apprehension.

A change of name will not prevent the venereologist in any way from continuing to diagnose, treat, and prevent syphilis, gonorrhoea, and chancroid. It will give him patients who will not be ashamed of consulting him and in my opinion it could do something to encourage recruitment to the specialty.—I am, etc.,

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Colour in Rhodesia

SIR,—I have recently served as senior examiner in the final examination for the degree of M.B., Ch.B. Salisbury and Birmingham. The hospital over which the question of "patient-apartheid" arose in fact does not exist. When completed in a few years, however, I find it impossible to believe that the splendid teaching staff, nurses, and medical students would behave any differently from what is accepted as good manners at the Teaching Hospital, Harari. There are only African patients at Harari—a few busy hospital. I saw no trace of apartheid-nonsense during my two-week visit. Moreover the atmosphere on the hospital campus was non-racial. The swimming pool for nurses and doctors was entirely "mixed," while more formal social or professional meetings ignored the race or colour of those attending.

Who will suffer if we desert our colleagues in Rhodesia? The African, whether near Salisbury or far out in the countryside where without doctors, midwives, and nurses the ancient tale of suffering will continue to be told. Surely no one intended to punish Rhodesia by cutting off medical aid? It is some consolation that the Senate of Birmingham is pressing for funds so that we may fulfil our moral obligation to those students already in training who set out in good faith to qualify M.B., Ch.B., Salisbury and Birmingham.—I am, etc.,

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